

TRANSCRIPT OF AUDIO FILE:

SAMHSA WEBINAR - INTEGRATING BEHAVIORAL AND PRIMARY CARE

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BEGIN TRANSCRIPT:

MODERATOR: Good afternoon everyone and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast titled “How to Integrate Primary Care Into a Behavioral Health Setting: Lessons Learned from the SAMHSA Primary and Behavioral Health Integration Program.” My name is Jenny Crawford, Deputy Director of the SAMHSA-HRSA Center for Integrated Health Solutions, otherwise known as CIHS, and your moderator for today’s webinar.

As you may know, the SAMHSA-HRSA CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. In addition to national webinars designed to help providers integrate care the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultation to providers and stakeholder groups, and directly working with the SAMHSA primary and behavioral health integration grantees and HRSA-funded health centers.

Before we get started, a couple of housekeeping items. To download the presentation slides please click the dropdown menu labeled “Event Resources” on the bottom left of your screen. These slides are also available on the CIHS website at www.integration.samhsa.gov, and located under “About Us/Webinars.” During today’s presentation your slides will be automatically synchronized with the audio so you will not need to flip any slides to follow along. You will listen to the audio through your computer speakers, so please ensure they are on and the volume is up. You may submit questions to the speakers at any time during the presentation by typing a question into the “Ask a Question” box in the lower left portion of your screen. Finally, if you need technical assistance please click on the question mark button in the upper right corner of your player to see a list of frequently asked questions and contact information for tech support if needed.

So this is our agenda today. We are going to be welcoming all of you, and our presenters will be going through introductions throughout the presentation. We’ll be discussing backgrounds on the health integration models in behavioral health settings and partnerships. We’ll have an overview

of clinical operations and financing and the workforce components of integration, as well as an overview of wellness and data considerations. Then there will be talking about lessons learned from the one hundred PBHCI, or Primary Behavioral Health Integration SAMHSA-funded grantees. We'll have some discussion and questions, and we'll wrap up. [0:03:00]

So today's speakers are Trina Dutta, Public Health Analyst and the Lead Government Project Officer for the SAMHSA grantees. I'm your moderator. We'll have Dr. Marie Hobart from Community Health Link in Massachusetts, and Freddie Smith, Program Manager from Alameda County Behavioral Healthcare Services in California. So with this I'm going to turn it over to Trina Dutta who's going to get us started with an overview about the PBHCI grant program. So we'll start with you, Trina.

TRINA DUTTA: Thank you Jenny, and welcome to all of the folks who have logged in for today's webinar. We're really excited to be able to share about the great work, what we've learned over the course of the primary behavioral healthcare innovation grant program. So I just wanted to start by giving you a brief overview of the work, of who the grantees are and sort of what they're charged to do. Here you see a map of the overall country and where we have grantees situated. Since 2009 when the grant program launched we've awarded grant dollars to 100 organizations to integrate primary care in community behavioral health settings. So just as a reminder, the program is specifically focused on serving adults with serious mental illness and co-occurring substance use disorders with the intention of connecting them with primary care services and having a positive impact on their overall health and wellness as a result of involvement in the program.

So since the program launched in 2009 we've funded 100 sites, 100 grantees I should say, across many more than 100 sites across six different cohorts. So we've had six waves of grantees that we've awarded since 2009. As of the end of this month we will have graduated 56 of those organizations, which means that they've finished their four years in the grant program. As you can see from the map we have locations all across the country, and since 2009 we've enrolled approximately I believe it's close to 48,000 or 49,000 clients have been enrolled in the primary behavioral healthcare services.

So I'm going to stop for a moment and have everyone participate in this polling question, which really gives us a sense of kind of for you all in the field what are your most pressing questions around integration of primary care. So you have five options here: whether it's paying for integrated care; whether it is models of integration; whether it's about the staffing and having the right staffing involved in your integration efforts; measuring outcomes of your integrated care; or partnering with primary care providers. And these are all issues we've seen across our 100 grantees that we've been funding. So we're going to start the poll now I believe, Jordan? [0:06:00]

JORDAN: Yes Trina, I have launched the poll for us. I'll give everyone another couple of seconds here to go ahead and cast their vote before I close the poll. [pause] All right, it looks like most of you have submitted your response, so I'm going to give about ten more seconds then I'll close the poll and share these results with everyone. For those of you that are having any audio problems, I have been responding individually. Well, I guess if you have audio problems you're

not going to be able to hear this either. But if you're with someone who doesn't have audio, make sure their speakers are all the way up. Okay, I'm going to close the poll now and send these results to all of you. Trina, are you able to see those results?

TRINA DUTTA: I am not able to see those results.

JORDAN: Okay, I will go ahead and share them with the audience. And we have 27.5% who are paying for integrated care, 30.5% said models of integration, 7% said the right staffing, 16% measuring outcomes, and the remaining 19% partnering with primary care providers.

TRINA DUTTA: Great, thank you Jordan. So that's very interesting to see kind of where folks fell out relative to the different challenges, or pressing questions I should say, that they have relative to integrated care. Particularly that only 7% felt that staffing was an issue for you. So that's really interesting for us to know.

So continuing in talking a little bit more about what we've been doing with regards to the primary behavioral healthcare integration grant program, there's a variety of different sort of approaches or models if you will for the actual integration of care. So the behavioral health organizations, about 78% of our grantees are partnering with some sort of primary care organization in order to embed the primary care services into their organizations. So that could be something like a federally-qualified health center, a HRSA-funded federally-qualified health center, a hospital, a private provider, et cetera. So close to 80% of our grantees are partnering in that way.

The latter are actually hiring their own primary care staff directly. So they are in essence changing the scope of their business model and the work that they do so that they're also direct providers of primary care services. And this means that there's other sort of associated elements they have to engage in as far as identifying a path for billing for those primary care staff, which could be impacted by having dual licensing, or empanelment with a managed care organization. And I will note that of the latter that are doing their own, hiring their own primary care, we see that these are oftentimes our rural providers are the ones that are doing their own direct hiring, oftentimes because they just don't have a primary care provider in their community that they can partner with. So that's some of what we've seen so far as far as models. [0:09:30]

Now as I said earlier, the purpose of the behavioral healthcare integration grant program is to establish projects to support the coordination and integration of services where we're co-locating primary care and specialty care services into these community-based mental health and behavioral healthcare settings. And the explicit goal for us is to improve the physical health status of adults with serious mental illness. So we're really focused on adults here with SMI who have or are at risk for a co-occurring, comorbid primary care condition or other chronic healthcare diseases. The objective is really to support the triple aim, which I'm sure most of you are familiar with, which is to improve the health of those with serious mental illness, to enhance their experience of care, which is really the quality and access and reliability of that care, and also to reduce or control the cost of care that individuals are receiving.

There's a number of core requirements that you can see here. The two most basic requirements are obviously to provide onsite primary care services, but then also to provide the medically necessary referrals. So that's another big piece of this program given the level of health need that a lot of the clients that are enrolled have been showing. And then in addition our clients must serve as a health home, and you can see those services listed there. Those are the same services that are related to the Affordable Care Act person-centered health home opportunity, Section 2703 of the Affordable Care Act. So our grantees are providing these services as shown in bullets one and two, but also serving as a health home for the clients they're enrolling.

Other areas of emphasis that are very important to the work that our grantees are doing is around health information technology. Grantees are required to achieve Meaningful Use Standard Stage 1 by the end of their four-year grant period. There's a strong focus on prevention and health promotion, where grantees are required to spend a minimum of ten percent of their grant dollars on wellness programming. And those programs include tobacco cessation, nutrition education, diabetes self-management, all sorts of different elements depending on the needs of their client population. And really a strong focus on making sure they're incorporating recovery principles and peer leadership and support within those prevention and health promotion activities. And certainly a really big focus for SAMHSA is sustainability, where grantees have to work starting from year two of their four year grant on sustainability planning, whether it be focused on Medicaid or Medicaid billing or other strategies that support the services post grant. [0:12:25]

And our grantees collect a fair amount of data that they submit to SAMHSA which really helps us understand how they're doing both clinically, but also with regard to some of the organizational developmental changes. So in addition to our national outcome measures that they collect which are focused on psychosocial measures like housing and criminal justice and employment and overall health and being connected to the community, our grantees also collect specific data relevant to the clients' physical health status. So it's baseline, and then either every six months or quarterly, every six months or a year, depending on the health indicator, grantees collect blood pressure, body mass index, weight circumference, breath CO, diabetes measures of fasting blood glucose and A1Cs, and then a complete lipid profile. And so that helps us again understand how clients are performing after they've been enrolled in the program, but also helps us work with grantees to help them understand what's working and what's not working.

So that's a quick brief overview of what SAMHSA is trying to achieve with our PBHCI program. And now I believe we're going to shift gears to our next speaker, Dr. Marie Hobart from Community Health Link. Dr. Hobart?

MODERATOR: Thanks Trina. I'm going to talk a little bit about your background, Dr. Hobart. Dr. Hobart is the Chief Medical Officer for Community Health Link and Clinical Associate Professor for the University of Massachusetts Medical School. She has devoted her career to working with community mental health for over 24 years. Her focus has been on those with serious and persistent mental illness and comorbid addiction and developmental disabilities. She's the Project Director for their primary and behavioral healthcare integration project. She's a graduate of the Yale School of Medicine and completed her residency training in psychiatry at

the Massachusetts General Hospital, a Harvard Medical School training program. So Dr. Hobart, thank you for being with us.

DR. MARIE HOBART: Thanks very much, Jenny. I'm hoping everybody can hear me okay. Thank you for that introduction. So Community Health Link is an urban community mental health center. We provide mental health and substance abuse rehabilitation services, homelessness services. We're the largest provider of mental health and substance abuse services in central Mass, and last year we served over 19,000 unique individuals. That's all ages—we provide child services as well. And about 70% of the population that we serve is comorbid for addiction and mental health disorders. [0:15:15]

So we received the grant four years ago, right now as a matter of fact, and what we have done with the grant is that we have developed onsite primary care, nurse care management, we've had a care support staff person who has primarily been leading a lot of our wellness groups, and we enrolled participants on a rolling basis from existing outpatients. When we started with the grant you could have either onsite primary care or you could continue to keep your outside primary care and just use the wellness services. So we have used a model of doing the entire integrated care program, or also wellness services for those who still have outside primary care. And this is just sort of a graphic model. We like to think of our services as being patient-centered. These are the various services that we provide. We have a tier advisory board that has become more active again in recent months and we're moving forward.

Just a little bit about who our population is. So we have enrolled in the portion of the program where we're collecting data about 438 participants, 52% male, 47% female. The ratio breakdown is the way that people recorded themselves, it is not necessarily... this is what is in Track, which is in the data collection system that we've been using for the project. And of interest, 19% self-reported that they didn't feel that they fit into any actual racial category, they said that they preferred not to be categorized in that way, which we found to be quite interesting. But as you can see we have quite a diverse population that we work with at Community Health Links.

These are the primary diagnoses. Our system is not the best at reporting out multiple diagnoses, and we have many people that have numerous physical health and mental health and substance abuse diagnoses that are comorbid, but certainly a large range of conditions that I'm sure many of you are familiar with in your settings as well. [0:18:00]

These are the concerns that individuals who started out at our services reported. These were the self-reports of individuals seeking services and what kinds of concerns that they had. You can see we had a very high percentage of individuals who smoked tobacco, as well as other substances, but certainly tobacco. Cardiovascular illness, respiratory illnesses, endocrine conditions, primary thyroid, and of course diabetes. We have a fair number of people that have had strokes, traumatic head injuries, other neurological disorders, seizure disorders. Digestive conditions, which include a lot of esophageal reflux, other kinds of irritable bowel.

Certainly dental concerns is a big issue, even in Massachusetts where we have fairly universal coverage at this point for dental care—not ideal and not complete coverage, but a fair amount of coverage. A lot of people with pain in terms of arthritis and other sorts of injuries that cause bone

and joint conditions. And then as you can see we've got a very large "other" category, and this includes a pretty high percentage of folks with infectious disease issues, whether it might be Hepatitis C, other infectious diseases, HIV. Reproductive health issues, particularly with our female patients, and a variety of other conditions as well.

So the [Roland?] Center of Community Health Link, we are a stand-alone model. So, as opposed to the models where there's a partnership with the federally-qualified health center or a separate provider of primary care that is coming into the mental health setting, we have actually hired and embedded our own primary care. So the primary care within the community mental health center includes individuals that have established care both within the center, but also like I said before we did start some wellness services for those that have outside primary care.

Our nurse care managers were really sort of the core of project at the very beginning and continue to be very central to the operation. They help to facilitate care with the mental health team and primary care providers, they provide education and support. So for example, if the primary care is working with someone on diabetes the nurse care manager might provide some additional practical education. And then actually our peer specialist might help them follow up with lifestyle changes, sort of direct how do you apply this in the real world. [0:21:15]

We have pretty close follow up to try to avoid having people fall through the cracks. Even in this kind of a project it can be challenging at times because sometimes we lose track of people from services because of all kinds of reasons, including change of address, change of phones, I'm sure things that you all are familiar with. We do a lot of wellness planning with individuals, primarily around nutrition, physical activity, smoking cessation, stress management, illness self-management. Everyone who meets with a nurse manager and/or the peer specialist are developing an individualized treatment plan.

We've done a fair number of groups. The whole health action management groups that are sponsored by SAMHSA is one of the groups. We've done other types of stress reduction, expressing yourself either in various types of creative ways, women's groups. We've had a pretty active group of individuals participating in fitness activities. We have an arrangement with the local gym where twice per week it's primarily clients from our center that are going during that time. Walking groups, yoga classes. And we've also developed a relationship with our local YWCA.

In terms of administration and infrastructure we went through many changes in the process of setting up this service. We initially attempted to partner with a local FQHC that was also having some challenges with recruiting providers at that time. We ended up partnering with the UMass Department of Family and Community Medicine and they helped us to be able to both retain a nurse practitioner that had been working in another program in our homeless services and to bring on some additional primary care providers over the course of the last four years.

The Department of Public Health in the State of Massachusetts was able to help us with licensing. It's different in every state. If you have an outside provider in Massachusetts and they're providing services on your site then you need to have two licenses, it can become very complicated. So we were actually fortunate to be able to get a waiver from the Department of

Public Health in Massachusetts in order to have joint waiting areas, which technically are supposed to be separate. Mental health, addiction, and primary care are supposed to have separate waiting areas, and we have one big old building that everybody comes in the same door and is looking for services. And it's actually worked out fine. [0:24:30]

Billing challenges. There are many billing challenges, and again, each state is different. We have been able to get community health center status at our place so we've been able to build a state Medicaid entity at a standard rate. We did have a lot of issues with becoming recognized as a primary care provider. We've been recognized for years as a mental health provider, but all of our peers were getting confused about recognizing us a primary care provider in this way. And we're now able to use CPT codes, we're able to bill Medicare. We have also been able to use the standard rate for community health centers for a good deal of our population. And I'm not the billing expert, but we've been able to figure out a way to make this sustainable. We're continuing with all of our primary care services, so that's the good news.

Electronic medical records. Huge, huge issue. We currently have a primary care record that is separate from the outpatient mental health records, but we are in process of developing an electronic health record that will actually integrate all the services of our organization, so our inpatient, addiction, residential, and also all of our outpatient services. There have been a lot of challenges, we have not successfully completed this project yet. We've been able to meet meaningful use for primary care and meaningful use for mental health but we have not made yet a fully integrated record. I'm hoping that if I was to talk to you all next year I would give you a happy and new story on that front.

There are lots of clinical management issues when you're setting up a program like this. Because we did our own primary care we of course had to hire our own primary care. We would have hired the nurse care managers anyway, but then we also had to hire a medical assistant, a primary care administrative assistant. We also actually have a practice manager that we ended up hiring to help us with the flow in primary care. And it is a very different skill set from traditional outpatient mental health, and we've been actually on the mental health side learning a lot from the flow in primary care. [0:27:15]

It's also been extremely challenging, yet so far we have ended up being successful having a peer specialist integrate into the primary care setting. Primary care is not used to working with peers in the same way that we have been in the mental health side, but our care specialist has really done a great job of helping people to operationalize in a very practical way their wellness plans, especially for diabetes, obesity, some work with folks on smoking cessation, and lots of other issues.

So let me also say that culture change is huge, and it really cannot be underestimated. We have really had to increase our shared sense that physical health is part of all of our work. That has been easier with some staff than with others. One of the ways I think that our program has facilitated that is that primary care is literally in the same hallway as where our therapy staff is, so our social workers, our licensed mental health counselors, our psychologists, our psychiatric nurses, we all just sort of walk back in the same space, we can walk, you know, individuals back and forth to each other's offices. And we have very low barriers for enrollment. I mean, literally

all you had to do is walk over and have somebody sign up. Because everybody in our clinic really suffers from pretty significant mental illness, lots of people with addiction, we just felt that everybody was really eligible for this program.

I think a lot of our staff even in their mental health counseling activities have really embraced the idea of wellness activities, both to help with physical health conditions, but also to help with mental health conditions. And we have done quite a bit periodically with wellness events, with putting wellness messages around the clinic, and it really helps to foster I think a great sense of respect for all the individuals that we work with, and to know that they want to take care of their health like anybody else does.

Some very practical things: We have two fully equipped exam rooms for one provider. We provide vaccinations. We have to have storage facilities, we have to have dirty utility. When you get into the nitty gritty of licensing and what you have to have and how it has to be set up you really learn. I can't tell you all the things that we've learned that have to be embraced. Because we have two records we actually have a separate reception and check in for the primary care. Hopefully that's going to be changing. And we've done a lot of work with reminder calls, tracking people. Our primary care clinic manager has been super helpful in making sure that the flow really works, both to see scheduled people and to see people that show up unannounced or that need an urgent visit. Even little things like supplies have to be tracked, refrigerators have to stay the right temperature, for vaccinations and other kinds of items that can spoil, just a lot of things. [0:31:00]

We've also had to figure out what's our urgent care coverage going to be. We've been fortunate to be able to work with UMass in that regard, as well as covering some of our own providers. We do have medical assistants, or an LPN who helps to room the patients, collect vital signs, reconcile medicines, do vaccinations. We do some onsite labs as well, although we can also send people next door to the Krest [sp?] lab that is right next to where our wellness clinic is. You know, urine tests, EKGs, all the usual things that you'd expect in a primary care office.

We have one small office, with the medical assistant, the nurse manager, and the primary care provider, sort of shared for charting. It's very tiny, but it promotes collaboration. We have a courier that comes to take samples away for anything that we don't send people out to the lab. And our primary provider is a nurse practitioner who's under the supervision of our medical director, our primary care provider in our homeless outreach program. But we have since actually added some hours from an additional primary care physician, another nurse practitioner, and we are sharing services with our healthcare for the homeless primary care. So there's been a lot of working together with that program, that's been very helpful.

I think that I've mentioned some of these items before, but being co-located actually just makes a huge difference in individuals being able to show up for services, to get the services that they need to feel comfortable. We do a lot of warm handoffs where we do direct introductions from the mental health staff to primary care. And sometimes it goes the other way around at this point, where somebody has ended up staying connected to primary care, has disconnected from mental health, and now we're trying to get them back into mental health services. It really does go both ways. We have a shared e-mail and phone system that helps us. Hopefully soon we're going to

have a medical record where we can do messaging right within the medical record. Right now we have to use the agency-wide e-mail and phone system, but it is secure, there's a firewall around it, so we're able to communicate pretty effectively. [0:33:40]

We have monthly provider meetings that include the psychiatric staff, the primary care provider staff. We have regular team meetings where we discuss issues, clinical situations. We're in the process now that we are finishing the grant of moving forward with integrated care rounds where pretty much anybody can come with lunch, discuss a case, discuss a topic, we're just working on that as well. And we I think have really developed this kind of shared sense of mission I would say in working with the population.

There can also be challenges in having primary care right in the heart of the mental health center. The mental health center tends to be I think a little bit more disruptive at times just in terms of, you know, if there are issues going on in the waiting area. Sometimes folks tend to just sort of come up to a door and kind of walk into an office and not sort of expecting that there's going to be a physical exam going on. We've had to really make sure that people know that they need to wait until they're called back for a visit, that's been a little bit of a challenge at times. We have really severe limitations, we're in an old building, we have sort of reconfigured this building so many times. It would be great to have a better physical facility.

Sometimes, especially at the beginning, trying to get all the data elements that we needed, all the tracking that we needed to do right when people are first signing up for primary care was kind of daunting for individuals, it was hard for them to do everything all at one time and we've had to make some adjustments for that. Our nurse practitioners in Massachusetts must be supervised by a physician. That is actually not true in every state. I have to say we've been very flexible about that, we have really good relationships between our nurse practitioners and our physician staff in general both on the psych side and the on the primary care side, and I think that that in general has worked out well, has been a strength, working together to figure out problems. And then it's always challenging to try to accomplish the physical healthcare for folks that are having a lot of mental health challenges, but it was a bigger problem before we had this program, a much bigger problem. [0:36:20]

This is just a list of a lot of the things we provide in primary care. Some people have the idea that maybe all we do is urgent care and then we just refer to ongoing providers in the community. That is not what we do, we really are the health home for people. We do physicals, we do pap smears, we do fecal [unclear 0:36:45] blood, looking for blood in the stool for colon cancer or other types of GI diseases. We do contraception. We schedule people for all their preventive services, so mammograms, colonoscopies, bone densities, anything that people need to do. All the diabetic screenings, foot exams, eye exams, all of those things. We don't have those things onsite, but because we are in partnership with UMass Memorial Healthcare we refer to the specialists there. We do vaccinations for flu, for [unclear 0:37:23], every time there's some type of vaccination that needs to be done we're able to do that.

These are the top five problems, physical health conditions, that we've found among the folks that are coming to see us. And many times they have comorbid conditions. I think as I mentioned at the beginning, tobacco use is just huge within our population. We've had some success with

people quitting smoking, but it's a challenge. Lots of people with hypertension, lipid disorders. We actually have a much higher percentage of people with diabetes in our wellness clinic and the mental health center than actually we do in the homeless population, that's been sort of interesting to note. Hepatitis C is very common in our area, both from sexual transmission and sharing needles, and that's something that we've been working on for quite some time.

So what are the benefits of the co-located model? The accessibility for people to just walk in, have open access. We determine the schedules both for primary care and for the mental health center, and we can have a very patient-centered approach in that regard. I think one of the keys to this type of service no matter how you set it up is being able to really be trauma-focused. I think so many of our folks just living with a serious mental illness, an addiction, causes a lot of trauma in one's life, not to mention domestic violence, early childhood trauma, other kinds of violence. [0:39:30]

And I think that people have also been traumatized in healthcare settings frequently, they feel like they've been misunderstood, that they perhaps have not felt respected, that they have been pressured to do things that they didn't feel ready to do and then couldn't participate and then felt pretty shamed and humiliated when they couldn't follow through with something, and they just didn't go back. So I think that we just expect that people are going to have challenges with everything and that we are going to be patient and really help people to be prepared to do the kinds of things that they need to do. And I think that that has actually allowed people to be much more comfortable and to actually get services that they haven't been able to actually follow through within many, many years.

And I think also because the mental health staff are right there they can really help a person to feel comfortable with going ahead and getting a physical exam. And even if it means all you're going to do is sit and talk with that primary care provider for a few visits before you ever even get to the point of a physical exam we've certainly done that on many occasions.

So we are, as we speak... I mean, the grant for us is essentially over as of this point. We are working with primarily payers right now in setting up payment mechanisms through... Massachusetts has fairly universal health coverage, there's a lot of experiments going on with Medicaid and Medicare, with different forms of payment reforms for Medicaid, as well as even the private insurers, although we don't have a lot of people with private insurance, moving with the direction of integrated care.

What we're really trying to do is to position ourselves as the provider of choice for people with really complex mental health, physical health, addiction, and often what goes with that is poverty and all the social determinants of health that make health so challenging. We have been really trying to again work with the payers to sort of work on what kind of a correct payment structure might be that will actually allow us to provide this level of care for these individuals. We're trying to work on becoming as efficient as possible. So we want to be able to provide as much time as people need to not make people feel pressured, but at the same time we want to provide services for as many people as possible who need our services. So it's always sort of a balancing act between flexibility and trying to allow more people who will keep appointments to come in. [0:42:30]

We're working on more groups. We're doing group visits for diabetes, we just started our group visits for obesity. We've always had a fair number of outpatient mental health groups, but I'm hoping that we can have more integrated groups as well going forward. We're working on trying to make true integrated care plans. We've been trying to develop this within the new electronic record that we're working on but even in the meantime really trying to have people in their mental health treatment plans to have physical health and wellness goals that are also going to help with depression, psychosis, bipolar disorder, helping people to stay in recovery from addiction, helping people pay attention if they have ADD. Physical health and wellness is such a huge part of mental health and wellness, the brain is after all part of the body.

So we are trying to also do more training for all of our staff, we've actually submitted a grant proposal to do universal training for all the staff in our agency around health behavior change. And we've used a lot of motivational enhancements in our addiction work, but really trying to broaden that into health behavior change as well.

So I think that that's the highlights. So I'll be around for questions and answers, and thank you very much.

MODERATOR: Thank you Marie. I'm now going to introduce to you one of our grantees on the West Coast. Mr. Freddie Smith has worked over 30 years in public health clinics and community health centers that provide primary and behavioral healthcare services to those who are uninsured or underinsured. Currently he is a Program Manager from Alameda County Behavioral Healthcare Services in California in the Office of the Medical Director. He's the Project Director for the grant from the program promoting access to health, their PATH project. He has a master's degree in public health administration from the School of Public Health University of California at Berkeley. Welcome Freddie. [0:45:00]

FREDDIE SMITH: Thank you very much. I have a problem with my computer right now, it just went dead on me, but I would like to go forward. I'm sorry, I'm panicking right now.

JORDAN: Freddie, if you have a hardcopy of your slides and you say "next" I'm happy to advance the slides.

FREDDIE SMITH: No, I don't. I was going to follow the monitor. Let me get some help in here. Can you go with some questions and answers until I can get some help?

MODERATOR: That's a great idea, let's do that. Emma, do you have some questions collated for us?

EMMA: Yes I do, there are quite a bit of questions for Marie. There have been quite a few questions around workforce. So can you talk a little bit about the role of psychiatry, and also how many patients physicians typically serve?

DR. MARIE HOBART: So that's a good question. The mental health side of our clinic, we have actually what's probably considered to be a pretty high caseload. I mean, if a psychiatrist would

be working full-time outpatient we consider a caseload to be about 100 individuals per day of employment, so if you really worked five days a week doing nothing but outpatient services you could have a caseload of 500. I will say that we probably have some of our psychiatrists that have been around for a very long time that do actually probably have that number of folks, although sometimes they're folks that are maybe doing pretty well and may not need to come in so often. On the primary care side we set up assuming that for a nurse practitioner—our provider in the wellness clinic has been a nurse practitioner—that for half-time that that provider might have around somewhere between 300 and 400 individuals. That number will probably go up somewhat as we start to have also a little bit more of a mix of different levels of severity of illness that people are presenting with as we sort of move forward into sustainability, but that's the number that we've been using right now.

EMMA: Okay, thank you. We also have some questions about your wellness group. Some people are interested in hearing more about your diabetes and obesity groups, and also whether you're able to bill for wellness, and if so how. [0:48:00]

DR. MARIE HOBART: Good question. So if we have wellness activities that are part of a medical visit. So the group medical visit for diabetes and the group medical visit for obesity is actually co-run by our nurse care manager who is also really a wellness expert, she's actually getting a master's degree in actually complementary and alternative medicine, and our primary care nurse practitioner. So we are not directly billing for the nursing services but we are able to bill for the medical provider for those visits. When our peer specialist for example does a walking group, does a yoga group, does a whole health action management group, we do not have anyone actually to bill for wellness services of that nature, we cannot bill in Massachusetts for peer specialists or for community health workers or health coaches, there's not a mechanism for that right now.

If a nurse care manager meets with an individual person and does a wellness plan outside of a medical visit that is also... we do have some of the new insurance models are starting to pay for some of that. In Massachusetts we have One Care, which is a partnership between Medicaid and Medicare for individuals obviously that are both disabled and of low income. That program is providing some funding for that, as is the primary care payment reform through Medicaid in the State of Massachusetts. We're also hopeful that there's a new health home initiative in behavioral health that's going to be coming out in Massachusetts probably within the next year and they will definitely have some funding for wellness in those services. [0:50:00]

EMMA: Okay. There are still several questions. We had a couple of questions regarding your client engagement. We have some folks who are interested in if you know what percentage of your total client population participates in the integrated care, and also have you engaged enough clients so that you can make this sustainable.

DR. MARIE HOBART: You know, so far we—and I don't have the numbers ready for it—we have continued to enroll people in primary care beyond the grant requirements for data collection. So I would say that right now in the wellness center itself we probably have about 500 individuals that are getting primary care. As I think I mentioned before, we are in the kind of fortunate position where we also have some primary care that used to be very much separated

from the rest of the agency, with healthcare for the homeless. And so we've been able to combine those two efforts to make a more general primary care for the neighborhood, quite frankly.

And we're now in the position of getting referrals from the insurance companies actually of people that have been auto-enrolled who may have been sort of disconnected from care, and they are primary. So in our primary care as a whole we now have about 3000 individuals. And I'm not the budget person and I'm not personally the one to do the math but I did meet with the budget person just before this seminar and she assured me that we're actually moving forward in a sustainable way with those kind of numbers and the way that we're being reimbursed right now. So I'm optimistic that we can keep moving forward with that.

EMMA: Okay. And we also had a few questions related to operations. You had mentioned that your primary care clinic operates two days a week. And so our participants are interested in knowing what happens during those non-operating days.

DR. MARIE HOBART: So actually right now the primary care clinic is operating four days a week. At the very beginning it was just two days a week, now it's operating four days a week. And during nights, weekends, holidays people can call in and we'll get a call back through our connection with UMass. Our providers participate in the primary care on call with UMass primary care and so our patients are able to avail themselves of that service. And they can also just go to the UMass Emergency Department if need be. During the day during the week our homeless outreach and advocacy project has pretty much walk in hours almost five days a week, Monday through Friday, nine to five. So even during times when the wellness clinic wasn't having active clinic, at outreach there's always a place where somebody can walk in.

FREDDIE SMITH: Okay, I'm able to participate now.

MODERATOR: Great.

FREDDIE SMITH: I apologize everybody, our Centrex system went down and it's up again now, so I'm ready to go.

MODERATOR: All right, thanks Freddie. And you'll have about ten minutes, if we can stick to the highlights that would be great. [0:54:00]

FREDDIE SMITH: Okay. I would first like to say that I was brought on in 2008 to Alameda County Behavioral Healthcare Services to really help the department identify a strategy for moving forward with integration. At that time all of us remember a lot of the literature was coming out about how our seriously mentally ill clients were dying 25 to 30 years earlier due not to mental health conditions but to chronic physical health conditions, and the major reason for that was a lack of primary care access. And Alameda County, we had a very non-supportive relationship with the primary care community, and so it was really an effort to really get started and push forward towards coming together to even just sit down at the table and say, "Okay, what can we do to better serve this population?"

So with that, our county has thirteen non-profit assertive community support teams, and also we have five county-operated programs. That has allowed us to go forward and put in our project, the PATH project, which it mainly stands for Promoting Access To Health, into two of those centers, one of those centers located in northern Alameda County, which is more urban, where you have mainly male predominantly African-Americans, and one program in our south county site in Fremont which is more suburban, serves more about Pacific Islanders, Latino, and also Southeast Asian.

And in September 2011 we opened up our first site at the lifelong primary care site where we brought in the primary care team into our Oakland mental health services site. This was a real big change in operating culture for the county. Never before had the county had services operating with a CBO staff right next to a county civil service staff. So this was a major change in culture. There were concerns about who's going to be giving directions to others, there was the whole issue of these were jobs that maybe we should be operating just within the county system, hiring our own medical providers and not contracting out services. So finally after a six-month meet and confer process we were able to get the approval of the Labor Relations Department to go forward with our project.

So we opened our first clinic in September 2011, and with that we've been able to enroll over the time 200 clients. In August 2012 we opened our south county facility at the Tri-City Adult Community Support Center, and we're partnering with a new primary care provider from that area called Tri-City Health Center. And we're serving currently about 80 clients at that facility. [0:57:00]

Now, as I mentioned, both of these providers are providers that have been operating since the 70s serving the uninsured and underinsured in Alameda County. What we do in terms of integration is that we bring in the primary care team, which is mainly the doctor, a medical assistant and a front office person, and we locate them in the behavioral health site. We have a behavioral health nurse who's a registered nurse, and a peer counselor and a clinic coordinator. After every PATH clinic we have what we call a huddle where we call it a debrief session. And this has been very successful in our project, where we've been able to at the end of each clinic day the doctor or the nurse practitioner leads the discussion about what they want followed for each client that was seen that day. They get input from the psychiatrist, they get input from the case managers, and they also get strong input from the peer counselors. We have the peer counselors who works with the clients in terms of helping them with transportation, they conduct and facilitate a lot of wellness group and activity, and they also help communicate client needs that quite often don't get discussed during a primary care visit.

And I'll give an example of that. Quite often many of our client, when they go to see a doctor they go for one emergency issue or a problem. But when they sit down with a peer on a one-on-one basis they get to discussing a lot of sensitive health issues. So due to that we've been able to not only identify such issues as STDs, identify Hep C, but we've also been able to reconnect individuals that have been out of care for such things as HIV, and that has been some major items that we've been able to do. Our peer staff have been able to talk clients into getting screenings like for cancer, where before many of them would never go up and complete a cancer screening test because of fear and at the same time just not wanting to go through that process

and have the patience to stick with it. Our wellness classes offer an opportunity for not only socialization, but also a chance for them to engage with other clients for support, and also receive motivation from each other.

The teamwork we have in our clinic is tremendous. The primary care providers really enjoy working with other doctors and case managers, our psychiatrists enjoy working with the primary care providers and the medical assistants, and then at the same time both of them feel like they're being listened to. And at the same time they're really happy because things are getting done. The referrals that we made are now being completed, whereas before we implemented our project those items were not being done, or very few of them were being completed. [1:00:25]

When we first started our organization and our project and we were funded by SAMHSA one of the biggest issues that came up was that we identified a lot of our clients that had not seen a primary care provider in over two years. So the project has been able to bring clients into care in an environment that they're very comfortable and at the same time feel very supported.

The challenges for our organization have been mainly the bureaucratic process. It's been very difficult and we required a lot of patience in terms of realizing how much time it takes to get things done, be it contracts, be it MOUs, there within a county governmental process. And we've had to really work with our primary care partners to really reassure them that we are moving forward and it's just taking a little bit of time.

The population served. When we deal with our clients one of the biggest things that we've identified is that we have a real huge substance abuse problem with many of our clients, and just because we offer mental health services we still need to do things that offer more support and recovery services for substance abuse. Our clients lack access to real good transportation, many of them live in unsafe neighborhoods, and especially those in Oakland where you have many of them living in unlicensed board and care home.

Staff changes for our clients can be very upsetting. They get used to working with an individual and all of a sudden this individual or a provider may get a promotion and move on to another opportunity, and it really takes time for our clients to really get used to a new staff person walking in and also a new provider.

The types of wellness activities that we offer. Each month we offer a calendar that talks about all of the beautiful activities that we're going to be offering for the month. So a consumer has the opportunity to select what they want to be involved in and at the same time would like to participate in. We've also had some of the case managers and psychiatrists recommend certain wellness activities and classes to clients so that they could really tell them how they could be supported by these activities. We offer healthy cooking classes, we have a meditation and movement, we offer luncheon learns that are often conducted by our primary care providers where they discuss a timely topic such as how to properly take your medications, diabetes education, stress management. Those are the things that happen. We also have the Living Well classes that are part of the Larry Fricks Whole Health Action Program. [1:03:40]

Now I'd like to give some tips about what can you do to really make your program successful. Number one, create a welcoming environment. We have carved out a little space in our open site where we call it the PATH café. And we put beautiful posters up for the clients so that they can see themselves, and also see different, you know, beautiful flower arrangements, or just different scenery with nature. This has been really well, because the clients come there and just sit and they socialize, they may have a cup of tea, and it's also a chance for them to ask questions with staff that they may not be able to ask during a primary care visit. The weekly cooking classes are very, very well attended, and at the same time we also go out as a group in those classes and go to farmers market and pick up the food that we're going to be using for that class.

Having fun. You definitely need to make your wellness activities fun. And some of our social work interns that we have had onboard, they have been the ones that really have assisted us in bringing a new creative energy. One of the things that we do in terms of naming our classes, we put a new spin on them. Like for example the smoking cessation class has now become Bye Bye Butts. Stress management or stress reduction is now Fun & Games. And our relaxation and meditation class has now been renamed Feel Good Fridays.

Health outcomes. A lot of you have been saying, well, basically have you been able to see a difference in the health outcomes of your consumers? So one of the things that we started doing in 2013, we started meeting with our decision support staff and the primary care partner's IT staff to really say, okay, what kind of data do we have that really showed some outcomes? Our lifelong medical group that we partner with, they provided us a data dump from their patient system and we were able to pull out some data that showed that for the blood glucose, blood pressure, and body mass index we were able to see improvement. [1:06:00]

If you would look at the outcomes you would see where basically for the non-PATH clients, which we looked at, they only had a 40% improvement, where if you look at our clients, we had 52%. If you look at the blood pressure there was 56% improvements, our clients had a 64%. And these are individuals that had before in the beginning abnormal blood results or metabolic testing results. In terms of BMI, in the non-PATH program there was 22% improvement, and in the PATH project our clients had a 64% improvement.

When we looked at the area of access we were able to see that one year prior to integration the low users of services only had a half a clinic, I'd say about 45 primary care visits a year. After integration those same individuals had 5.1 increase in visits. For the heavy users, we had the heavy users one year prior to our PATH project and integration they were utilizing the primary care system almost 13 primary care visits a year. After enrolling in our PATH project that went down to almost 6.3. As all of you know, the average for most adults is 3.5 primary care visits, and although they are still over that average, I think when you look at the health condition of our clients and the mental illness factors and you take them into consideration that's great improvement. We're also making sure that a lot of our clients are getting referred to specialty care services which before they were never able to receive.

Tips for going forward in your project on integration. Work with your evaluator. If you have a program evaluator evaluating a service work with them and your data team to plan what data you want to collect and when and how. Measure the changes in your blood pressure, blood sugar, and

breath CO, and cholesterol levels. And also track your visits, with to primary care before and after.

One of things that we did to get more staff support and stakeholder support was to offer a vision retreat, and we've done two so far in two years. And one of the things we asked the staff and the stakeholders who attended was what can we do to improve upon what is working, and where do we want to go from here. And I tell you, the suggestions and ideas have been great. One of the major things that has come up for us is there was an issue with clients that were still very hard to reach. There's always a small percentage of clients that regardless of what you do they don't show for their appointments. [1:09:20]

So the suggestion that came up in our vision retreat was to offer a clinic on check day. And check day is when the clients come in and see their case manager for their spending stipend. That was so well received, because, again, we all know that if a client is going to show up at any time it's going to always be for check day. So what we've done is we are now rearranging one of our clinic days to be on clinic day, and so that we can identify and pull in on an open access model clients that don't have appointments but still need to start getting in to a primary care provider and be seen.

Sustainability. We took a real strong role in making sure that we found out ways that we can sustain our project. And in California we are very fortunate to have California... they call it California Mental Health Services Act dollars, which is has been there to fund a portion of our PATH project and sort of support the SAMHSA grant funds that we also receive. As we move out of our grant with SAMHSA we're going to be relying really heavily on those Mental Health Services Act dollars to fund our program. But we've also looked at other sources of funding to sustain our program. One, we're looking at our behavioral health bill, Medicaid administrative activities, and targeted case management services.

We're also going to be looking at additional funding from outside foundations. Right now we're in the second year of funding from the San Francisco Foundation for a \$30,000 grant for three years, and we're in the second year of that. And that's been a grant to help us look at how we can sustain our project and also keep planning. We're also right now because of the additional allocation and the great job that we've done, our executive leadership has funded us now to open up two new sites and two more community support centers going forward, one will be in San Leandro and the other one will be in Hayward, California. We also receive small grants from [MSHA?] to deal with tobacco cessation. And they're very small, but they also fund some activities for our supplies and some medications. [1:12:10]

The big thing we're doing right now and we're still awaiting word on is that we've applied for a grant in collaboration with UC Berkeley School of Psychology to do a sleep research on our clients at our community support centers and our PATH project where basically we're going to look at ways to improve the sleep of our clients that are enrolled in a project. So most of our [SMI?] clients have... or when I say most, 85% of them have sleep disorders.

MODERATOR: Hey Freddie, this is Jenny.

FREDDIE SMITH: Yeah.

MODERATOR: I'm going to thank you at this junction, because we've got 15 minutes left, and I think this next slide is really pretty self-explanatory for our audience and thank you for those tips.

FREDDIE SMITH: Okay.

MODERATOR: And I'm going to just move us forward a little bit so that we don't run out of time, but thank you so much. We also wanted to just talk generally about the lessons learned as we've seen them, and the lessons learned have come in from different audiences. One is a series of lessons learned identified by the 43 grantees who recently graduated in a coaching session that we had this summer, and those are the slides that follow. We also have some information from a national evaluation conducted by RAND. And then we have a combined set of lessons learned from these grants, primarily from SAMHSA but also a few from us at CIHS. So with that I'm going to turn this over to Trina and she can advance the slides to where she wants to highlight some of the lessons learned. So Trina.

TRINA DUTTA: Thanks Jenny. And I just want to thank both Freddie and Marie for great presentations highlighting kind of what we're going to talk about right now, which is lessons learned. So we have an abbreviated amount of time left today so I'm going to go really quickly through just highlighting one item on each of these slides since I think some of these are sort of self-explanatory.

So as far as coordinated care, I think one of the pieces that's resonated most strongly across our grantee community is that working with care coordinators often was... it turned out to be nurse care coordinators, has been really crucially important to the integration of primary care and behavioral health services insofar as they're really providing a link and a bridge and playing traffic cop and having a lot of other roles that support sort of this integrated care. So that's been a major finding, or a major lesson learned across our grantee community, is the role and importance of sort of a set aside person to do care coordination, oftentimes a nurse care coordinator.

I'm not going to touch on some of these other pieces other than having very good clinical tracking is important. Freddie just mentioned, a number of his tips are all related to data and using data and measurement and tracking what you're doing so that you can make a statement about the value of the work. [1:15:15]

The next slide, communicating. Again, I think both Marie and Freddie spoke to this, but meeting regularly, the opportunity for teams to work together, both with regards to the primary care and behavioral health staff to talk about the work that's happening both at the clinic level, sort of organizationally, but also with regards to client improvement and client needs. And that's been important not just for the health and improvement for the clients that are being served, but also to help address some of the culture divide between primary care and behavioral health. So communication and meeting regularly has been an important piece that our grantees have learned about over the course of their careers as PBHCI grantees.

The next slide on communication, that's what I said in here, it is crucial and has been very important both to the success and sometimes lack of success that our grantees have experienced. Getting to see buy-in at the kind of executive level, so from your CEO, your CFO, your Chief Medical Officer, all of the C-suite, getting them involved at an early stage and having them constantly connected with what you're doing with regards to your integration is really important. It gives you buy-in with regards to other staff around this kind of changing model to integrating primary care into behavioral health, but also ensures that the CEO can communicate to other parties about the work that's happening, whether that be to state government, whether it be to county and local government, whether it be to payers, to your managed care organization, et cetera. So it's really important to get the buy-in early and make sure that you're communicating often with your chief officers around what's happening with regards to your integrated care.

With regards to wellness, it's important here to really base the interventions and activities on what the clients want. And that could be informed by both the clients in speaking to them, doing focus groups and activities to elicit from them what is going to be important and what's going to work, but also utilizing what you know about the client health and wellness outcomes relative to the physical health data that you're collecting. But what we've seen is that sometimes our grantees move out and they're very excited to have groups focused on diabetes management or tobacco cessation, and then they realize that maybe the groups aren't really what their clients need and so they shifted their approaches to have different types of groups or to really move more into a one-on-one approach with clinicians working one on one with clients versus having groups. So that's an important finding, is to base what you're doing on what the clients want or need. [1:18:15]

Sustainability. This is obviously a hugely important issue for SAMHSA and our federal partners, is sustaining these PBHCI activities. So from our perspective it's really to start early on that conversation. A lot of our providers maybe start talking about sustainability in the fourth year, but now we're requiring that these conversations... that there's actual sustainability planning happening in the first and second year that is being implemented over the course of the program. So not only are the kind of core grant primary care and wellness services being rolled out, but also implementation of the sustainability plan. And that's related to some of these other bullets that you see here that also support the implementation of sustainability planning from year one.

As Jenny mentioned, SAMHSA and our federal partner ASPE, the Assistant Secretary for Planning and Evaluations, provided funds to the RAND Corporation to do an evaluation of our grant program, and there were actually three questions that they sought to understand. One was is this type of integration possible? A second question, do people get better? And a third question was what are kind of the core features of that integration? And you can see at the bottom of your slide, you can go to our final report on that evaluation which gives you a lot of really rich detail around what is working and what's not working for the grantee community.

But just specifically to some of the outcomes, I saw some of the questions coming in are focused on the physical health outcomes. What RAND found is they took a small sample of clients being served at three of our sites and did a comparison with three non-grantee mental health centers and looked at twelve months' data around outcomes. So they looked at baseline and then twelve months' follow up data. And they found that for clients that were enrolled in our program there

was a strong improvement generally around cholesterol, some moderate improvement shown around diabetes and hypertension, but that we had a lot more work to do and needed more efforts around both adjusting obesity and smoking.

And I'll just note that one of the things that we've discussed is also looking at if you look at these health outcomes relative to the ease of getting somebody connected to medications around these health issues. Cholesterol, you can get someone on medications for the cholesterol and you'll start seeing a pretty quick impact. Similarly for diabetes and hypertension, but there's also some health behavior changes that need to be made with regards to diabetes and hypertension. But then obesity and smoking, there's quite a bit of health behavior change that needs to occur to impact obesity and smoking. So these findings weren't terribly surprising, but we also feel that if we were able to do a longer-term analysis, maybe over two years or two and a half years, that we'd see a stronger impact across things like obesity and smoking. [1:21:15]

So moving forward, I'll just quickly touch on a few more, then hopefully we'll have time for some Q&A. Other successes both that we've seen from the SAMHSA side of talking to project doctors but also our technical assistant center is the second piece here that our grantees have been really successful in changing their state and local policy to support the integration and care. There's a lot of local policy that sort of inhibits the innovation in services, so our grantees have had success there in working to move through those. Also been really successful in bridging across the different electronic data systems that behavioral health and primary care staff are using. And actually if you go our www.integration.samhsa.gov there is quite a bit of information on how to address electronic health records across diverse systems and using different systems, so I'd encourage you to take a look at that.

Challenges. Of course there have been challenges, which we will talk about. We've had a number around substance use disorders, which I think actually Freddie alluded to earlier. But partnerships with the federally-qualified health centers has been a challenge, that without obvious financial incentives meaningful participation has been difficult. So that's been one thing that a number of our grantees have been struggling with. Not all of our grantees, but some have had really lovely partnerships with their federally-qualified health centers. But that has been an ongoing challenge.

Another challenge is for our rural sites. Even for those sites that our grantees that have been able to find and bring on primary care capacity, there's still a challenge given issues around transportation and accessibility. So our rural grantees still continue to struggle with having kind of robust access to primary care services. So that's been one challenge, and you can see these other challenges. A number of the questions were on wellness services, getting billable wellness services has also been a big challenge for our grantees.

So again, we talked about in the beginning that our real goal here is to achieve the triple aim through the PBHCI program, and that's again where we're able to see improvement in health outcomes. We're doing an analysis right now to see whether we are able to impact cost because of PBHCI services, and so those findings will hopefully be ready in the next year. And then we've definitely seen improvements around the consumer perspective of their experience of care. [1:24:00]

And a number of the questions that came through today were looking at some of the other things that PBHCI is focused on or related to, things like Medicaid health homes, a number of states are focusing on people with serious mental illness, and actually the PBHCI program is mentioned in the health homes efforts, the state Medicaid director's letter. There's a number of innovation programs coming out of CMS that focus on people with serious mental illness and substance use disorders and connecting them with primary care. Efforts around hospital and ER reduction, certainly the work we're doing through PBHCI touches on that. And then models around managed care organizations and kind of doing system reform around how you're serving these clients.

So I think that sort of rolls us through to hopefully... Oh, sorry, I forgot to go through those. So those are some of the issues that our grantees are connected with. So Jenny, I'm going to turn it back to you because I think we have a little bit of time for some questions, so I'll turn it back to you to get us going through those questions.

MODERATOR: Okay. So Emma, if you can come up with like two other questions for right now, and some of you we'll get back to individually with some of the questions that you submitted. And then as Emma's gathering those just please remember to respond to the short survey at the end of this webinar because we do appreciate your feedback. So Emma, what questions do you have?

EMMA: I know that Trina had talked on this a little bit, but we have received quite a few questions around EHR, so I thought it might be helpful if Marie and/or Freddie can address those. Some of the questions that we had was concerning challenges of not having the EHRs talk to one another, some of the workarounds that you have developed around that, plans for the future to get them talking. And also what vendors they are using.

DR. MARIE HOBART: Freddie, you want to respond?

FREDDIE SMITH: Yes. Currently we're having to use both the primary care providers' EHR, which is NextGen, and our behavioral health EHR, which is Clinicians Gateway. The county is in the process of getting ready to develop a new EHR, or select a new EHR, that will be compatible with NextGen. In Alameda County the Healthcare Services Department provided the funding for the eight community health centers to purchase NextGen, so all of them have the same identical system, and that's NextGen. And we will have a system in the near future that will be compatible to that system.

MODERATOR: Marie, can you answer that too? [1:27:00]

DR. MARIE HOBART: Yeah. So we are trying to build something with a company that's called Advanced Data Systems Corporation out of New Jersey to build an integrated record. I wish that we had a more coordinated effort like Freddie is talking about at sort of the state level or the county level. And it's a work in progress, so I can't say that I would recommend it. Right now primary care is in the ADS system and mental health is in the old version of VSet, which is the

NextSmart technology, our original EHR that we've had for I think eight or nine years at this point. So it's a challenge.

MODERATOR: And so on our website at www.integration.samhsa.gov there's a lot of information there around health information technology. We're not endorsing any particular company, but there is information there about sharing records, meaningful use, continuity of care documents, et cetera. Emma, another quick question?

EMMA: I know we're running out of time, but I think this might be a good one to end with. We had a couple of questions about tips for how to be successful at integration when you don't have PBHCI funding.

MODERATOR: So Marie or Freddie, do you have suggestions for what you would have done if you hadn't had funding?

FREDDIE SMITH: I think we would have probably still proceeded. Because again, our Department of Behavioral Healthcare Services is also committed to going forward with a primary care provider. The first year we applied for a SAMHSA funding we did not receive approval, but our department still was going to provide Mental Health Services Act dollars to at least start one integration project instead of two. And we also had going partners that were willing to step in from primary care and take the risk to be a partner with us and make sure that they would do their part. We were just going to make sure that we guaranteed them the clients so that they could cover their cost, and at the same time we had some Mental Health Services Act dollars to help make up the difference. But go forward.

MODERATOR: Thank you, Freddie. That's all the time we have today. I want to thank all of our speakers, and again ask you as you exit the webinar to please complete a short survey, and to encourage everyone who has additional questions to visit the website www.integration.samhsa.gov. Thank you all for joining our webinar and please stay tuned for more webinars in the future, and have a great afternoon.

END TRANSCRIPT